LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV
MEETING MINUTES
September 8, 2011

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*/Kevin Lewis	Dean Page	H. Avilez	Kyle Baker
Michael Johnson, *Co-Chair*	Angélica Palmeros	Robert Contreras	Mary Orticke
Sergio Aviña	Mario Pérez	Zoyla Cruz	Juhua Wu
Al Ballesteros	Karen Peterson	Susan Forrest	
Nettie DeAugustine	Juan Rivera	Shawn Griffin	
Whitney Engeran-Cordova	Stephen Simon	Tim Hughes	**COMMISSION STAFF/CONSULTANTS**
Aaron Fox	Robert Sotomayor	Ayanna Kiburi *(by phone)*	
Douglas Frye	Carlos Vega-Matos	Luke Klipp	Erinn Cortez
David Giugni	Tonya Washington-Hendricks	John Leahy	Dawn McClendon
Joseph Green	Kathy Watt	Sandrine Lewis	Jane Nachazel
Thelma James		Sonam Patel	Glenda Pinney
Lee Kochems		Terri Reynolds	James Stewart
Bradley Land	**MEMBERS ABSENT**	Michelle Roland *(by phone)*	Diane Tan
Ted Liso/James Chud	Anthony Braswell	Herb Schultz	Craig Vincent-Jones
Abad Lopez	Joseph Cadden	Alejadrina Turnado	Nicole Werner
Elizabeth Mendia	Lilia Espinoza	Jason Wise	Adrianne Wynn
Quentin O'Brien	Anna Long		
Jenny O'Malley	Edwin Sanchez		
Alberto Orozco/David Kelly	Fariba Younai		

1. **CALL TO ORDER**: Mr. Johnson called the meeting to order at 9:15 am.
   - **A. Roll Call** (**Present)**: Ballesteros, Chud, Giugni, Green, James, Johnson, Land, Lewis, Lopez, Mendia, O'Malley, Orozco/Kelly, Palmeros, Peterson, Rivera, Simon, Vega-Matos, Washington-Hendricks, Watt

2. **APPROVAL OF AGENDA**:
   MOTION 1: Approve the Agenda Order ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION 2: Approve minutes from the 8/11/2011 Commission on HIV ***(Postponed)***.

4. **CONSENT CALENDAR**: Motions 4, 5 and 6 were pulled for deliberation, so no motions remained on the Consent Calendar.
   MOTION 3: Approve the Consent Calendar ***(Withdrawn)***.

5. **PARLIAMENTARY TRAINING**: There was no training.

6. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
   - Ms. Lewis, Outreach Worker, JWCH, Inc., asked about TAP cards not being reloaded. Mr. Vega-Matos said clients no longer need to load them at agencies. Agencies should load cards monthly via internet. They are updated automatically the next time swiped. The MTA TAP card has replaced bus/train passes and bus tokens. Taxi support remains the same.
   - Consumers with a TAP card problem should contact their agency's medical transportation coordinator. A card will not be reloaded if recertification of current medical appointments and care plans is overdue, but will be reloaded after recertification.

7. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: Mr. Aviña complimented Mr. Pérez on his National Council of La Raza presentation in Washington, DC.

8. **CO-CHAIRS' REPORT**: Mr. Johnson noted continuing County discussion on LIHP implementation. PLWH receive care in some areas that still lack LIHP providers. The Board has given the Department of Health Services (DHS) authority to issue contracts, but planning challenges remain. He urged providers present to contribute updates on their situations under Item 17.
   A. **Joint Commission/PPC Annual Meeting**: The Annual Meeting will be at the Wilshire Hotel on 10/5/2011, 8:30 am to 5:00 pm. Mr. Johnson noted the meeting this year will be on a Wednesday.

9. **EXECUTIVE DIRECTOR'S REPORT**: There were no reports.

10. **CALIFORNIA OFFICE OF AIDS (OA) REPORT**:
   A. **California Planning Group (CPG)**:
      - Ms. Kiburi, Chief, HIV Care Branch, reported work continues on the Comprehensive Plan due to HRSA in June 2011.
      - The Prevention Funding Opportunity Announcement (FOA) is complete and in review. Once released, the CPG will review it for consistency with its plan. CPG met two weeks prior on Prevention FOA allocations and to hear stakeholder input.
      - Ms. Watt asked if the CPG planned a letter to the CDC responding to the Prevention FOA prior to release of the Prevention Planning Guidance. Dr. Roland, Director, OA, said the CPG would make that decision.
      - Governance documents on CPG's structure have been posted on the Advisory Network for public comment.
      - Travel remains restricted, but the CPG continues to meet regularly by webcast and teleconference.

   B. **OA Work/Information**:
      - Ms. Kiburi reported OA is working collaboratively to provide guidance on the transition of RW clients into the LIHP.
      - Dr. Roland added that FAQs from a call three weeks ago are being reviewed and will be posted on the website soon. The two FAQs previously posted have been updated to reflect information since the original calls. The FAQs underscore that OA will ensure time for agencies to plan the transition to the LIHPs for clients and for the agencies themselves.
      - OA has drafted the next guidance, which explains the transition process. It now allows an indefinite amount of time to create LIHP screening plans. OA also created a stakeholder group at the request of several stakeholders. Members are mainly RW and LIHP stakeholders in the ten legacy counties now enrolling in LIHP. A stakeholder group call that day would inform written stakeholder feedback due 9/9/2011. The guidance will be released to Part B providers 9/14/2011.
      - Ms. Kiburi said OA is assessing what Part A jurisdictions are doing regarding Early Identification of Individuals with HIV/AIDS (EIIHA) and formulating guidance to assist Part B grantees. Work has been hampered by loss of several staff involved in the work, but Ms. Kiburi hoped to have guidance for contractors completed in October 2011.
      - Dr. Roland reported the Health Care Reform HIV Preparedness Summary was completed and posted on the website under "What's New." Mr. Land, Jeffrey Goodman and Mr. Vincent-Jones were among contributors.
      - A survey will be announced the week of 9/12/2011 on the Advisory Network for input on the summary, such as what is helpful, not helpful, confusing or needs to be prioritized. This is the first use of the Network's survey function.
      - Surveys will be used more as CPG develops draft documents. Sign up for emails or surveys at www.oa@advisors.com.
      - Dr. Roland said she will be leaving OA to become the Country Director, Tanzania, Global AIDS Program, CDC. She has a long personal history in Africa, but will miss OA. Recruitment information is not yet available, but people can forward suggestions to her. Mr. Johnson thanked her for her work on behalf of the Commission and consumers.
      - Mr. Engeran-Cordova asked if OA has run drills on LIHP versus ADAP savings. He noted PLWH were not necessarily expected to be in LIHPs, but now counties face LIHP medication expenses previously covered by ADAP so help via ADAP savings is pertinent. Dr. Roland said OA is working on detailed estimates for the November ADAP Estimate in the

Governor's January Budget. OA has provided ADAP expenditure, revenue and net expenditures tables at 25% of Federal Poverty Level (FPL) increments to counties. People can use the data for their own estimates. It is on the website.

- Ms. Watt asked if there had been any contingency planning regarding the 10,000 prisoners returning to counties as of 10/1/2011 and being released shortly after. Dr. Roland said there have not been any calls on the subject.

11. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT:

A. HIV Epidemiology Report

- Dr. Frye, Chief, HIV Epidemiology Division, reported migration of the database to the State in Sacramento is proceeding well considering variables among the CDC, State, San Francisco and Los Angeles. Weekly teleconferences address issues as they arise. The testing phase of integrating the database has begun. Integration is expected in October 2011.
- He noted numbers may appear smaller due to the increased de-duplication effort among states and counties. The CDC required increased effort to count and Include deaths which has reduced numbers nationwide.

B. Administrative Agency Report:

1. ***FY 2011 Ryan White Part A Award***: Mr. Pérez reported receipt of the FY 2011 HRSA Ryan White (RW) award with an increase of about $386,000. For the first time, the total award exceeds $40 million, which is especially good in the current economic climate. HRSA gave five-and-one-half pages of strengths and no weaknesses, but the score does not fully reflect that.
   - ➲ DHSP will provide a summary of HRSA's application review at a later date.
2. ***Low Income Health Programs (LIHPs)***: Mr. Pérez noted a series of conversations with providers on migration to the local LIHP, Healthy Way LA (HWLA). A meeting was scheduled at the DHSP offices at 3:00 pm to update providers on current DHS and Department of Public Health (DPH) approaches.
3. ***FY 2012 Ryan White Part A Application***: Mr. Pérez said the FY 2012 application is due 11/1/2011. More staff will shift to it after some CDC applications are done.
   - ➲ DHSP will develop a timeline with the Commission regarding FY 2012 application elements sometime in October.

12. PREVENTION PLANNING COMMITTEE (PPC) REPORT:

- Ms. Watt reported Amy Wohl, HIV Epidemiology Division, DHSP, gave a colloquium at the 9/1/2011 meeting on her study of "Low-Risk Sexual and Drug-Using Behaviors Among Latina Women with HIV/AIDS in Los Angeles County." Discussion followed on Latina and African-American women's needs as prevention funding shifts to 75% core/25% support services.
- A Co-Chair contingency plan was approved to ensure smooth transitions. Terry Smith, Community Co-Chair, will end his term in December 2011 and the Community Co-Chair-designate will begin in the next quarter.
- The PPC also affirmed the importance of attending both the Joint Commission/PPC Meeting and the regular 10/6/2011 PPC meeting.
- The CDC Prevention Planning Guidance has still not been released, though the FOA requires a response . The PPC is drafting a letter to call attention to the discrepancy and urging community members to voice their concern.

13. TASK FORCE REPORTS:

A. Community Task Forces: There were no reports.

B. Comprehensive Care Planning Task Force (CCP TF): Ms. Watt said the next meeting will be 10/25/2011, 9:30 to 11:30 am.

C. Commission/PPC Integration Task Force (CPI TF): Ms. Watt said the CPI TG met the previous week. The Plan is nearly ready for presentation at the Annual Meeting. It shows where integration occurs across prevention, treatment and care.

D. Health Care Reform Task Force (HCR TF):

- Ms. DeAugustine reported significant activity around the LIHPs. DHSP called a meeting 9/1/2011, which was helpful especially in providing consumer information. Another meeting was scheduled later that day.
- Mr. Chud asked if there was a graphic to help consumers visualize how they will move from RW to LIHP to Medi-Cal.
- The next HCR TF meeting will be 10/9/2011, 9:30 to 11:30 am.
- ➲ Mr. Johnson said two briefs on HCR provide LIHP information, but a graphic will be developed for the consumer brief.

14. CAUCUS REPORTS:

A. Latino Caucus: Mr. Aviña reported the Caucus expects to meet in October.

B. Consumer Caucus:

- Mr. Vincent-Jones noted the response in the packet from Toby Douglas, Director, Department of Health Care Services (DHCS), to the Caucus letter on denial of Medical Exemption Requests (MERs) from Medi-Cal managed care for PLWH. While the letter clarifies the DHCS point of view, Mr. Vincent-Jones encouraged continued engagement as he has not heard that other populations consistently receive denials. People should still report denials to the Commission.

16. STANDING COMMITTEE REPORTS:

A. Priorities & Planning (P&P) Committee: Commissioners stated their conflicts prior to P&P deliberations.

1. ***FY 2012 Contingency Scenario Directives***:

- Mr. Land noted base allocations were approved at the 8/11/2011 Commission meeting. Contingency scenarios are designed to address possibly decreased RW funding and/or increased savings from migration.
- Mr. Ballesteros said P&P reviewed scenarios and developed two sets of contingency directives based on priority rankings and net cost savings or net reductions. Both allow DHSP flexibility to address changes as they occur.
- Net Cost Savings Directives are:
  - Maintain or increase Medical Outpatient/Specialty (MO/S) for clients remaining in RW system; any realized savings can be applied for these additional purposes:
    - Increase funding for treatment adherence services;
    - Increase support for lipodystrophy treatment, as allowed;
    - Increase support to expand availability of MS services, as needed;
    - Provide funding for ancillary MO/S services, as needed and allowed;
    - Implement optometric services.
  - Maintain or increase Medication Assistance and Access, as needed, to improve access to non-formulary medication assistance, including increased support to improve availability of nutritional supplements.
  - Increase funding for Oral Health (OH) services.
  - Expand Linkage To Care (LTC) services with emphasis on enhancing treatment education services.
  - Increase funding for Benefits Support.
  - Maintain or increase Medical Care Coordination (MCC) services.
  - Maintain support for services that LIHP may cap such as Mental Health (MH) and Substance Abuse (SA).
  - Increase funding for MH (Psychiatry and Psychotherapy):
    - Increase support for both Psychiatry and Psychotherapy services; and
    - Increased support for Psychotherapy should be used, in part, to ensure continuity of care when gaps result from intern rotation.
  - Allocate to/increase Medical Nutrition Therapy (MNT).
- Mr. Sotomayor asked what LIHP MS information was needed to determine actual outcomes. Mr. Land replied P&P cannot yet determine how often clients will exceed LIHP MS caps and need to access RW care. MO/S is the top-ranked priority, so P&P felt it critical to ensure the RW system remained intact to assist as needed.
- Mr. Vega-Matos added DHSP was continuing to do side-by-side comparisons of LIHP and RW MS services. LIHP will have some medical specialties not currently part of the RW system and, to date, no drastic limitations are apparent. In the end, clients may have access to more specialty care under LIHP, but final details are not known.
- Mr. Chud asked about LIHP MH coverage. Mr. Vega-Matos replied it was still being defined, but there will be three coverage tiers. The directives provide flexibility to ensure client MH coverage and provider service transition.
- Net Funding Reduction Directives are:
  ① Preserve all core medical services possible, to the extent possible.
  ② Hold the following services harmless (maintain their allocations at the expense of cuts to other service categories), in order of their priority rankings:
    - Medical Outpatient/Specialty (MO/S);
    - Medication Assistance and Access;
    - Oral Health (OH);
    - Linkage To Care (LTC);
    - Benefits Support;
    - Medical Care Coordination (MCC);
    - Mental Health (MH), Psychiatry and Psychotherapy.

  ③ Cut whole service categories from the lowest priority ranked up as funds become unavailable.

- Mr. Engeran-Cordova complimented P&P, but felt it key to emphasize RW will change dramatically after 2013. To revise RW and argue its relevance after 2013, it must take into account the entire care chain from finding PLWH, identifying them, testing them, linking them into care and wrapping services around those they can access through other means. He urged specifically addressing client identification and linkage to care going forward.
- Mr. Vincent-Jones noted the Commission was addressing the subject through multiple efforts: SOC is developing an LTC standard; LTC is being incorporated into priorities and planning; the CCP, CPI and HCR TFs are all addressing Testing and Linkage to Care Plus (TLC+); and JPP is considering it as part of reauthorization principles.
- Mr. Vega-Matos added DHSP has a cross-division working group using TLC+ as an organizing principle. Mr. O'Brien noted some DHSP and DHS provider engagement, but it must continue through RFP development and contracting.
- Ms. Washington-Hendricks was concerned net funding reduction directive #3 could harm clients by cutting MO support services such as Transportation. She urged plans to help clients access other services. Mr. Ballesteros said such cuts would be in the worst case scenario. Many lower ranked categories have minimal funding now and would not be viable if reduced. Mr. Vincent-Jones added directives prepare the landscape. Once funding and migration numbers stabilize, it will be possible to identify what additional planning will be needed.
- Ms. Watt, Executive Director, Van Ness Recovery House, noted they reviewed care history at a staff meeting. Staff not active 15 or 20 years ago were unaware of how needs were addressed before such service categories as transportation and even before RW. There are lessons from the past that can apply to today's challenges.
- Mr. Engeran-Cordova asked if Directives met DHSP needs. Mr. Pérez felt Directives a helpful roadmap. He highlighted key concerns that DHSP will be watching over the next six months that affect funding:
  1. The FY 2011 RW award increased by about $386,000 over FY 2010 through 2/28/2012, so funding is available now.
  2. The main issue is migration to LIHP, expected to begin October 2011. DHSP wants to maintain continuity of care for as many as possible with only a payer change. Total estimated migration has dropped to 4,750.
  3. The Congressional Super Committee was to begin meeting that day. It is charged with reducing spending and/or increasing revenue by a minimum of $1.5 trillion by Thanksgiving. Should it fail, there will be across the board cuts. That must be closely monitored to assess impacts to Health and Human Services (HHS) and RW.
  4. Early next year there will be additional County transition steps across multiple departments including DHS and DHSP in collaboration with providers. Details were being finalized prior to the 3:00 pm meeting with providers.
  5. There are multiple movements in play, e.g., to coordinate with other revenue streams. There are also efforts to improve linkage to and retention in care that will place demands on the RW system, such as with a strong HIV case-finding effort to identify the 13,000 undiagnosed and the 15,000 diagnosed but not in care.
  6. The FY 2012 award is unlikely to be received prior to 3/1/2012. HHS and HRSA are no doubt aware how critical it is to receive the award promptly and how hard planning for potential adjustments will be if it is not.

MOTION 4: Approve the FY 2012 contingency funding scenario directives, as presented ***(Passed: 25 Ayes; 0 Opposed; 0 Abstention)***.

2. ***FY 2012 MAI Allocations***:

- Mr. Land noted proposed revisions minimize disruption in a time of flux and maximize resources.
- Mr. Engeran-Cordova asked if oral health could absorb more resources. Mr. Vega-Matos replied DHSP has increased oral health investment and is continuing with an expansion plan to increase capacity. The first phase of that plan is $1.6 million which is more than the MAI increase. He noted LIHP does not include dental services, so costs remain.
- He continued that funding for the oral health increase was taken from Early Intervention Services (EIS), as it is significantly underspent and under internal work group review. EIS services now are a collection of varying legacy programs.
- Mr. Pérez added the Commission has prioritized oral health for several years to meet growing need. Initially providers said they could offer more services, but did not. Mr. Vega-Matos' team has since led site visits at 10 providers and developed a two-phase plan. Phase 1 purchases additional services from six providers with existing capacity.
- Mr. Sotomayor asked if services include, e.g., dentures. Mr. Vega-Matos said they do and would continue to do so.

MOTION 5: Modify MAI allocations in FY 2012 as follows: increase Oral Health (OH) from 20% to 30%; reduce Early Intervention Services (EIS) from 35% to 25%; and maintain the Medical Care Coordination (MCC) allocation level at 45% ***(Passed: 25 Ayes; 0 Opposed; 0 Abstention)***.

3. ***FY 2011 MAI Roll-Over Allocation***: There was no additional discussion.
   MOTION 6: Re-allocate $269,785 in MAI YR 3 carryover funds from Early Intervention Services (EIS) to Oral Health (OH) ***(Passed: 25 Ayes; 0 Opposed; 0 Abstention)***.
4. ***FY 2011 Revisions***: There was no additional discussion.
5. ***Core Medical Threshold Waiver Request***: Mr. Vincent-Jones reported P&P postponed the subject to its 10/25/2011 meeting to allow time for trends and patterns to develop.

B. Standards of Care (SOC) Committee:

1. ***Pol #05.8001: Grievance Process***: Mr. Vincent-Jones noted that public comment had been continued until 11/30/2011. Dr. Younai will present on it at the 11/10/2011 meeting. Meanwhile, work will continue to gather input from HRSA, which is required prior to final approval.
2. ***DHSP Grievance Findings***:
   - Ms. Orticke, Chief, Quality Management, DHSP, presented on the DHSP Grievance Program. It meets RW program requirements; helps resolve client issues not resolved at the agency level; identifies trends in services relative to access, delivery and quality; and information can be used to identify trends and improve services.
   - Grievances can be filed by clients and advocates, contracted providers, HIV/AIDS stakeholders and the general public. There are five ways to file. The DHSP hotline, 800.260.8787, has a live operator 8:00 am to 5:00 pm, Monday through Friday. Grievances can be left on voicemail after hours for follow-up the next business day. Grievances can also be mailed, faxed, emailed via the Public Health or DHSP websites, or submitted in person.
   - The DHSP English- and Spanish-language posters distributed in 2009 inform clients of their right to file a grievance and how to do so. All contract provider service sites must place posters where clients congregate.
   - Ms. Orticke said DHSP found the six Patient's Bill of Rights categories too generic. Instead, managed care categories were identified from a literature search. The nine issue categories and types identified are: enrollment, benefit, client, service administration, care/service access, service provider, perceived appropriateness and quality of care, DHSP related and non-jurisdictional items which are referred to the appropriate bodies.
   - The seven DHSP Grievance Process steps are:
     1. Receipt (intake);
     2. Open case file and assign to reviewer;
     3. Investigate which may include more information from the filer, site visits/focus reviews, and/or collaboration with other agencies;
     4. Identify and address quality of care issues with all parties;
     5. Determine grievance status of verified/substantiated or not verified;
     6. Close case and send correspondence to all parties;
     7. Track reports.
   - There have been 187 grievances filed involving 37 agencies from 2008 through August 2011.
   - In 2010, 52 grievances were filed via: Grievance Line, 29; general DHSP phone, 11; email, 7; and letter, 5. Filers were: client/advocate, 40; provider, 4; HIV stakeholder, 4; and anonymous, 4. Service categories addressed were: housing, 16; Medical Outpatient, 15; grantee, 3; Dental, 3; Transportation, 2; Substance Abuse, 2; Case Management, 1; ADAP, 1; and unknown, 1. Two grievances pertained to prevention services.
   - Distribution of 2010 grievances was: SPA 1, 0; SPA 2, 6; SPA 3, 1; SPA 4, 27; SPA 5, 1; SPA 6,1; SPA 7, 7; SPA 8, 3; unknown, 6. Of 20 agencies with grievances: 1 agency had 11 grievances, 2 had 6; 1 had 4; 3 had 3; 3 had 2; and 10 had 1 each. Agency complaint trends are reviewed and addressed. DHSP conducted site visits/audits in 9 agencies.
   - Service provider complaints was the largest category at 15 for unprofessional behavior, disrespectful treatment, disclosure of confidential information, harassment, client not included in care, and not helpful/responsive.
   - Service administration had 13 for delay in service requests usually regarding records, unlawful eviction, fiscal/financial fraud, non-payment of subcontractors, and no interpreter. Fiscal complaints are addressed by the Financial Services Division and may be elevated to the Auditor-Controller.
   - Quality of care/services had 8 grievances for changes in medication regimen, falsifying records, referral delays to housing or dental and delay in obtaining medications or refills. Often these are due to miscommunication on the need for referral eligibility documentation. Consumers and agencies are educated about documentation needs.
   - Benefits issues represented 7 grievances for housing, eviction notices and hotel vouchers.
   - Access to care/services had 6 grievances for denied bus passes, cancelled support group meetings, denial of level 3 dental procedures, including lack of service awareness, lack of same day urgent care and poor service explanation.

- Total grievances versus those substantiated are: 2008, 42 versus 5; 2009, 34 versus 3; 2010, 52 versus 13. The percentage of substantiated grievances rose in 2010 due to increased issues and improved investigation processes.
- 2010 outcomes were: agency aware, met client's needs, 25 with 9 substantiated; client referred to another agency, needs met, 11 with 1 substantiated; referred to other government agency for action, 8 with 3 substantiated; agency aware, 6 with 0 substantiated; case closed (no information from client), 2 with 0 substantiated.
- A quarterly update with summary and details is presented at DHSP program division manager meetings. A summary is presented bi-annually at senior management team meetings. Summary presentations are available for planning bodies and quality of care subcommittees, excluding client and agency information.
- Mr. Engeran-Cordova complimented the report and noted grievances are low considering the number of clients.
- Mr. Land noted Roundtable feedback was that complaints were addressed well. He felt it remained important to educate consumers. Ms. Orticke noted managed care reports are about half those received by DHSP per population. Mr. Vega-Matos added agencies also resolve many grievances through their own processes.
- Mr. Sotomayor asked about housing eviction complaints. Mr. Vega-Matos replied that DSHP is involved if the service is funded by DHSP. Complaints that pertain to Section 8 or other housing are referred to the proper body.
- Mr. Sotomayor asked about information sharing. Ms. Orticke said information is shared with involved parties such as the agency with complainant permission. Aggregated data is shared internally and with, e.g., the Commission.
- Mr. Sotomayor asked about record review. Ms. Orticke replied DHSP looks for documentation of activity around date(s) of the complaint. To review patterns, DHSP also reviews a sample of other records for the contract term.
- Ms. Washington-Hendricks asked if specific complaints from a SPA were available. Ms. Orticke said generally only the aggregated data is available. More details are available to an agency about complaints that pertain to it.
- Ms. Mendia asked about disrespectful behavior and harassment complaints as they relate to cultural competency, especially regarding transgenders. Ms. Orticke replied both DHSP and the agency investigate a complaint and investigations are compared and analyzed, including as to cultural competency. DHSP also plans more training.
- Ms. O'Malley said it was important for agencies to verbally remind clients that they can file grievances. Her agency distributes free cards with various free lines such as the Grievance Line, HIV LA, peer support and crisis lines.
- She asked why some filers choose anonymity. Ms. Orticke said DHSP often knows who the person is and urges openness, but some fear retaliation. It makes addressing it harder, but DHSP often can identify issues via trends.
- Mr. Liso urged people to first repeat the problem to the complainant, so they are aware it will be followed up. Agencies should be alert that continuing complaints or fewer clients generally are personnel issues.
- Ms. Orticke thanked DHSP contract providers for their cooperation in addressing complaints.

➲ The Consumer Caucus will discuss how to address fears of consumers in reporting grievances.

3. ***Consolidation of Standards of Care***: Ms. Palmeros reported work continues on consolidation to streamline standards and ease adoption by other systems. A table of standards approved for consolidation was in the packet which shows standards reduced from 35 to 26. SOC plans to develop more consolidations to reduce the final number to about 16.

C. Joint Public Policy (JPP) Committee: The next JPP meeting will be 9/28/2011. The next RWR TF meeting will be 9/14/2011.

D. Operations Committee:

1. ***Commission New Member Orientation***: Orientation was postponed due to the Commission meeting's length.
2. ***Miscellaneous***:
   - Ms. O'Malley reminded by name those with overdue renewal applications to turn them in promptly.
   - Mr. Page announced after much thought, prayer and talk with his wife and family he had regrettably decided he needed to resign from the Commission for personal reasons. He held the work over these nine-and-one-half years close to his heart. He thanked Mr. Land for opening the door and Messrs. Ballesteros, Butler, Johnson and Vincent-Jones; Mses. Bailey and DeAugustine; the Consumer Caucus; and staff. He said he would continue to advocate for consumers living with HIV/AIDS and hoped to be back one day. Commissioners applauded Mr. Page. Mr. Engeran-Cordova added Mr. Page's voice has been unique, honest and unvarnished. He thanked him for making a real contribution and making him a better commissioner.
   - Ms. Watt noted the Commission had now lost two people who acknowledged being formerly incarcerated IDUs. It is a voice hard to bring to the table and critical to understanding the population.

17. PUBLIC HEALTH/HEALTH CARE AGENCY REPORTS:

A. US Department of Health and Human Services (DHHS) Report:

- Mr. Simon introduced Herb Schultz, Director, Region IX, HHS. He formerly served as Senior Health Policy Director for Governor Schwarzenegger, Acting Secretary of Labor and Work Force Development for Governor Davis, Director of Government Affairs for AIDS Project Los Angeles (APLA) and has a long history of addressing health care issues.
- Mr. Schultz thanked the Commission for inviting him and the many mentors at the table who taught him about Los Angeles and California when he moved here 13 years ago for the APLA position after 7 years as a PLWH.
- He also honored the memory of Howard Jacobs who fought tirelessly, passionately and boldly on behalf of PLWH.
- He said there are challenges, but also opportunities for collaboration. It is virtually impossible to separate issues with the Federal and state budgets, the California 1115 Medi-Cal Waiver and Federal healthcare reform in the Affordable Care Act (ACA). There are cuts, but also funds entering Los Angeles County through ACA and LIHP.
- Previous Democratic and Republican administrations used his job for public relations not community education and empowerment, but President Obama and Secretary Sebelius know it is key to work with stakeholders such as labor, consumers, providers, health plans, academics, business and nonprofits for efforts such as ACA and the 1115 Waiver to succeed. His job is at the intersection of politics and policy to ensure collaboration before regulations are even drafted.
- ***Health Care Reform***: ACA healthcare exchanges for individuals and businesses with less than 50 employees will affect healthcare overall. A national listening session is scheduled in Sacramento on 9/22/2011 specifically for California on exchange issues such as eligibility, enrollment, seamless coverage between Medi-Cal and commercial coverage, and tax credits. Participants will include representatives from HHS, Centers for Medicare and Medicaid Services (CMS), Treasury, and Center for Consumer Information and Insurance Oversight (CCIIO).
  - Proposed regulations do not yet define essential benefits. Once defined, other programs such as Medicaid must mirror them. He has emphasized that across Region IX (which includes California, Arizona, Hawaii and Nevada; the Guam, American Samoa and Northern Marianas Islands territories; and the nations of Micronesia, Palau and the Marshall Islands), which receive public health and prevention funds. HIV/AIDS is a key concern across the area.
  - Secretary Sebelius will propose a minimum benefits package in the Fall, but the law is broad, e.g., "ambulatory care services, mental health and substance use parity, pediatric dental and vision." The Secretary will define actual services, co-payments, deductibles and so on. He recommended impacting development, not waiting for the draft, to ensure RW population needs are met. CMS and HRSA provide services, so are limited in what they can discuss. He offered his email and cell phone and urged joining the listserv that distributes summary policy points and includes grant opportunities.
- ***National HIV/AIDS Strategy***: Mr. Schultz chairs the Regional Council for Region IX. The unique Council has 18 Federal counterpoints from, e.g., Justice, State, Housing and Urban Development (HUD), Social Security Administration (SSA), Veterans Affairs (VA).
  - Broad department engagement is important due to social determinants of health impact ACA and the 1115 Waiver, e.g., SSA is helping to address low numbers of seniors and people with disabilities in the Medicare Part D program.
  - All Region IX HIV/AIDS-related agencies will meet 9/21/2011 on operationalizing NHAS in the Region. Participants Treasury, Labor and HHS were lead agencies on HCR and will participate in the national strategy to eliminate racial, ethnic and geographic health disparities which has additional related funding. Community input is encouraged.
- ***Low-Income Health Program***: He noted that he recused himself from 1115 Waiver discussions when he was in Governor Schwarzenegger's office as he was seeking his current office. He did ensure there were HIV/AIDS, LGBT and other community voices.
  - He joined the Governor's office over a month after the law was signed. Federal law did not preclude the Waiver and he talked with Dr. Mary Wakefield, Administrator, HRSA, about HRSA guidance. She urged him to gather community input.
  - Mr. Fox wrote him when the guidance was released and found it helpful. He has since heard about problems with the shift from annual to bi-annual screening and is working with Dr. Wakefield to ease implementation. The Federal government wants to engage and he continues to work to break down silos between the various agencies.
  - People can call him 24/7 with issues, e.g., Kathy Ochoa, SEIU, noted a $30 million County partnership on work force development bolsters entry-level skills while HCR funds only higher-level positions. That is now under review.
- ***Questions and Answers***:
  - Mr. O'Brien stated the County fought hard over 30 years to develop a robust and responsive system for PLWH. He felt the system was on the verge of rupture beyond repair. Medical services may or may not survive, but he

expressed concern that the LIHP pharmacy distribution network will break. Half the ADAP-eligible population will move to a network that excludes major pharmacies such as Rite Aid and other ADAP pharmacies. If people cannot get medications, then viral loads will spike with increases in infections, disease acuity, opportunistic infections and resistance.

- Mr. Schultz agreed pharmacy issues are real. Oversight is local, but he continues to work with Secretary Sebelius and Dr. Wakefield to identify such issues and solutions to them. He will talk with Dr. Wakefield 9/12/2011 on issues raised.
- Mr. Land raised the issue of physician access, especially for seniors like himself, who see six specialists for various health care problems. Another need is mental health support to stay compliant with the complexity of care needed for PLWH. Mr. Schultz responded that he did not know whether people had thought RW would not be impacted, but is addressing issues now.
- Mr. Liso agreed the medication problem was paramount. His own bill would be $2,700 per month. Housing is another key issue to stabilize care. Federal and State proposals would further cut housing funding.
- Mr. Schultz replied HHS has a role via CMS regarding the Med-Cal budget. He has not heard much from the community on caps and cuts. It is most helpful for him as a lobbyist to receive information in a format such as, "If this cap is put there in this part of the community, then that equals X (bullet points)." The State has proposals at CMS that reflect what the enacted State budget did, but must receive CMS approval to implement them.
- Mr. Pérez said the last five months have been frustrating. Regardless of how ACA was developed, people have tried to engage since. There were many PLWH voices that were solution-oriented, but they were met with Federal and State inaction. Federal officials including Jeffrey Crowley, Director, Office of National AIDS Policy (ONAP), said they wanted California to exemplify a smooth transition to ACA, but then have not responded to issues, e.g., Los Angeles County will inherit a $40 million pharmaceutical bill. Mr. Schultz appreciated outreach to other Federal officials, but Region IX was not advised. He did not excuse what did not happen elsewhere, but said issues addressed via regions are framed in a more concrete manner with many solved.
- Mr. Pérez expressed concern that if LIHP was not done properly the result will undercut NHAS principles of reducing disparity, increasing access and reducing HIV infections. Mr. Schultz replied that perspective was helpful.
- Mr. Chud noted he and other long-term survivors recently discussed the LIHPs, and that they found no advantage to it, especially regarding depression which is the top issue for 50+ and long-term survivors.
- Ms. Watt noted drugs and alcohol often lead to infections, yet the Substance Abuse and Mental Health Services Administration (SAMHSA) has very little involvement in LIHP. While silos are being addressed, SAMHSA remains apart. Mr. Schultz replied Secretary Sebelius recently asked the ten regional directors what was missing. Lack of a SAMHSA regional presence was everyone's number one. Ten regional directors are being hired. Meanwhile, he continues to do what he can. He understands, while ACA parity issues are real, LIHP issues must be addressed first including to what degree wrap-around services are possible. He has raised concerns with Pamela Hyde, Administrator, SAMHSA.
- Mr. Engeran-Cordova expressed concern about several large-context NHAS goals, e.g., almost 10,000 people on ADAP waiting lists, payer of last resort as it pertains to LIHPs, states cutting funds and rolling responsibilities to counties. He felt better leadership and action was required from the Administration and the President.
- He also felt it important to be judicious in discussing these issues at the Commission table so that consumers are not unduly frightened. There are issues, but there are also dedicated people working on them.
- Mr. Johnson agreed that as a PLWH it is easy to feel betrayed as they were left out in the development of the LIHPs and still are not heard. He works for DHS with smart people and is the contracting liaison for HCR. Each solution offered to get medications to people has been undercut. DHS itself has few dispensaries as it has used commercial ones. It cannot even serve its own clients. Senior leadership should not require something that does not exist without time to create it.
- Mr. Sotomayor asked who created the LIHPs. Mr. Schultz said he did not know if it was a Federal, State or community idea. Among California healthcare coverage initiatives, the then-expiring County five-year Waiver covered those up to 200% of FPL. Expanding that statewide was raised when Federal/State discussions began. Most current issues were not raised to him then despite speaking with the HIV community. A reporting piece that reviews a substance use benefit was spurred by the California Association of Drug and Alcohol Executives who asked why only mental health was included.

- Mr. O'Brien said LIHP itself is a great program for people who had no payer source, but PLWH had a payer source for a robust system. They are being forced into LIHP through a quirk of the law and Federal interpretation of it. It is that quirk in the law that needs to be fixed, noting that regulations can be re-written
- Ms. DeAugustine wanted Mr. Schultz to know people at the table have worked their entire lives to reform healthcare for everyone and still want that. They want it to work and expand access. They just need time to make it work.
- Mr. Vincent-Jones agreed with Messrs. O'Brien and Pérez that the 1115 Waiver was meant to be a demonstration project for the nation, but he felt Federal partners have not acted like partners and have often acted as adversaries. HRSA has said, for example, that a six-month screening has been in place a long time, but has never asked, "How can we help?" nor questioned if this was the best time to insist that it be implemented.
- Another issue the Commission raised two years ago is "funding of last resort." It is not even properly applicable in California as counties have that standing and it has proven to be a major concern with wrap-around services. He felt HHS should reconsider that issue as part of reauthorization.
- Finally, he pointed out the RW system has forged an understanding of PLWH quality of care. He hoped the discussion of essential benefits will include what can be taken from the RW system and learned or even imposed on other systems to ensure quality. Mr. Schultz replied investments for quality in the exchanges have been made, but the only major piece of exchanges regulation that is on quality, is not yet complete as input is still being taken. He strongly urged talking with him on it now, e.g., he has standing calls with many communities. It is key to participate in developing regulations, not wait for the draft. The agenda is being set, RFPs developed and funds there. There is commitment to an open process.
- Mr. Schultz said his key takeaways were: last resort funding, wrap-around services, lack of response to input, not requiring something that doesn't exist and transition time. He is an advocate, albeit internal, and seeks feedback.
- ➲ Mr. Schultz will update Ms. Watt on the SAMHSA regional director recruitment timeline. Offices have been identified.

18. **SPA/DISTRICT REPORTS**: There were no reports.

19. COMMISSION COMMENT: There were no reports.

20. **ANNOUNCEMENTS**: There were no reports.

21. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 1:05 pm in memory of Vicki Casanova.

A. Roll Call (**Present)**: Aviña, Bailey/Lewis, Ballesteros, DeAugustine, Engeran-Cordova, Green, James, Johnson, Kochems, Land, Liso, Lopez, Mendia, O'Brien, O'Malley, Orozco/Kelly, Palmeros, Pérez, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Watt

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the 8/11/2011 Commission on HIV.	***Postponed***	**POSTPONED**
MOTION 3: Approve the Consent Calendar.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 4: Approve the FY 2012 contingency funding scenario directives, as presented.	***Ayes:*** Aviña, Bailey, Ballesteros, DeAugustine, Engeran-Cordova, Giugni, Green, James, Johnson, Kochems, Land, Liso, Lopez, Mendia, O'Brien, O'Malley, Orozco, Page, Palmeros, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Washington-Hendricks ***Opposed:*** None ***Abstention:*** None	**MOTION PASSED** **Ayes**: 25 **Opposed**: 0 **Abstention:** 0
MOTION 5: Modify MAI allocations in FY 2012 as follows: increase Oral Health (OH) from 20% to 30%; reduce Early Intervention Services (EIS) from 35% to 25%; and maintain the Medical Care Coordination (MCC) allocation level at 45%.	***Ayes:*** Aviña, Bailey, Ballesteros, DeAugustine, Engeran-Cordova, Giugni, Green, James, Johnson, Kochems, Land, Liso, Lopez, Mendia, O'Brien, O'Malley, Orozco, Page, Palmeros, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Washington-Hendricks ***Opposed:*** None ***Abstention:*** None	**MOTION PASSED** **Ayes**: 25 **Opposed**: 0 **Abstention:** 0
MOTION 6: Re-allocate $269,785 in MAI YR 3 carryover funds from Early Intervention Services (EIS) to Oral Health (OH).	***Ayes:*** Aviña, Bailey, Ballesteros, DeAugustine, Engeran-Cordova, Giugni, Green, James, Johnson, Kochems, Land, Liso, Lopez, Mendia, O'Brien, O'Malley, Orozco, Page, Palmeros, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Washington-Hendricks ***Opposed:*** None ***Abstention:*** None	**MOTION PASSED** **Ayes**: 25 **Opposed**: 0 **Abstention**: **0**